Apply today

1. Choose your cover

Decide which level of health cash plan cover is best for you and complete section A of the application form. If you choose a family policy, please **remember to include your family's details, or they will not be covered.**

2. Add Care4

Do you want to add Care4 to your plan? If so, **complete section B.**

3. Declarations and payroll authority

In all cases, please ensure you have read and understood the declarations. **You should tick the boxes to indicate that you agree with the terms.** By signing the payroll deduction authority in section C you agree for premiums to be deducted from your salary and forwarded to BHSF.

4. Send your form back to us

Return your completed application form to:

FREEPOST RTJT-AHJY-BTRK, BHSF LIMITED,
2 DARNLEY ROAD, BIRMINGHAM B16 8TE.

5. Sit back and relax

Once your application has been processed, we will send you a welcome pack with full details of how to claim and access the services provided.

What our policyholders say

All claims handled smoothly and quickly

"I have claimed dental, optical, physio and chiropody. All claims handled smoothly and quickly by post. I have never needed to telephone."

I would find it difficult if I could not claim on my policy

"I would find it difficult to pay out the full amount for dental/optical services if I could not claim on my policy. I feel reassured that I have access to claim towards the bills."

Claims dealt with quickly

"The hospital day-case surgical benefit has come in very useful. It takes a weight off your mind knowing you get a little benefit at what can be a difficult time. Claims dealt with quickly."

Always efficient and helpful

"Enquiries are always dealt with quickly. Claims are paid very quickly. Always efficient and helpful."

OS921 04/17

GROUP NUMBER

REP NUMBER 47

PRODUCT CODE BF

The Health4All health cash plan application form

Applicants are requested to complete all applicable sections and return the entire form to **FREEPOST RTJT-AHJY-BTRK, BHSF LIMITED, 2 DARNLEY ROAD, BIRMINGHAM B16 8TE.** All insured persons must be normally resident in the United Kingdom and reside at the same address. Any dependent children to be covered must be under 18 years of age.

A

1. Tell us about yourself:

Title Surname

Forename(s)

Address

Town

County Postcode

Date of birth Union membership number

Telephone

Email

2. Please complete your employer's details:

Employer's name

Employer's address

Postcode Payroll number

3. Choose your level of cover by ticking one box:

	Personal cover Covers policyholder only		Family cover Covers policyholder, partner and dependent children	
	Bronze	£5.78 per month	Bronze	£11.56 per month
	Silver	£13.00 per month	Silver	£26.00 per month
	Gold	£20.00 per month	Gold	£40.00 per month
	Platinum	£27.50 per month	Platinum	£55.00 per month
	Diamond	£36.00 per month	Diamond	£72.00 per month

4. Would you like to cover your family? (Family plan only)

Complete their details below:

■ I wish my application to cover my partner, whose full name, date of birth and gender are:

Title Surname

Forename(s) Date of birth Sex M/F

■ I wish my application to cover my children, whose full names, dates of birth and genders are:

Name Date of birth Sex M/F

Name Date of birth Sex M/F

Name Date of birth Sex M/F

If more than three children are to be covered, please supply details on a separate piece of paper.

5. Have you previously been insured by BHSF?

Policy number Last premium date

Where was it paid? State either employer's name or direct to BHSF

6. Please read the following declaration:

I understand that:

■ No hospital in-patient claim will be paid during the first two years of my policy in respect of any health condition which existed or was being investigated before cover commenced and

■ BHSF may wish to verify medical information to support a hospital in-patient claim.

I agree to abide by the policy terms, and I acknowledge that they may be varied, as may the range or rates of benefits and/or premiums, if deemed necessary.

I declare that all the information I have given in this application is true, and that, if found to the contrary, claims may be rejected or the policy may be cancelled at any time.

I understand that my personal information will be used in accordance with the Data Protection Act 1998 by BHSF (and relevant BHSF Group companies) and by other companies who may provide a service under this insurance. This information may also be used for the efficient administration of the insurance, to monitor and continue to improve these services, and for the detection and prevention of fraud.

☐ I have read and understood this declaration. (Please tick)

Signature

Signature Date

☐ We may advise you, from time to time, about other products and services which may be of interest to you. If you do not wish to receive this information please tick the box.

If you wish to add life insurance to your policy, please complete section B in purple opposite.

In all cases, please ensure you have read and signed the payroll deduction authority (section C).

Once complete, please return your application form to: FREEPOST RTJT-AHJY-BTRK, BHSF LIMITED, 2 DARNLEY ROAD, BIRMINGHAM B16 8TE.

B If you wish to add life insurance to your policy, please complete sections 7 - 9 below.

PRODUCT CODE
K4C

7. Please detail who is to be insured:

- My full name and date of birth is:

Title Surname

Forename(s) Date of birth

- I wish my application to cover my partner, whose details and gender are:

Title Surname

Forename(s) Date of birth Sex M/F

(Couple cover is only available if you have selected a family health cash plan policy)

8. Choose your cover by ticking one box:

	Personal cover Covers policyholder only		Couple cover Covers policyholder and partner
	£2.70 per month		£4.68 per month

9. Please read the following declaration:

- I am applying to BHSF Employee Benefits Limited for life insurance cover in the sum of £5,000.
- I understand that no cover is available for any pre-existing condition or related condition until a period of two years has passed during which there have been no symptoms, tests, medication, other treatment or medical advice concerning such condition.
- I wish to take out Care4 insurance as indicated.
- I understand that variation can be made to the sum insured and/or monthly premiums if I am given at least 30 days notice of the change at my last known address.
- In signing this application form I understand that my personal information will be used in accordance with the Data Protection Act 1998 by BHSF Employee Benefits Limited (and relevant BHSF Group companies), certain Lloyd's underwriters and by other companies who may provide a service under this insurance. This information may also be used for the efficient administration of the insurance, to monitor and continue to improve these services, and for the detection and prevention of fraud.

☐ I have read and understood this declaration. (Please tick)

Signature

Signature Date

☐ We may advise you, from time to time, about other products and services which may be of interest to you. If you do not wish to receive this information please tick the box.

C Payroll deduction authority

10. Please confirm your employer's details:

Employer's name

Employer's address

Postcode | Payroll number

11. Please confirm your cash plan premium:

Please deduct the appropriate amount of premium from my pay and apply it to my BHSF policy as follows (tick one box only):

	Personal cover Covers policyholder only		Family cover Covers policyholder, partner and dependent children
	Bronze £5.78 per month		Bronze £11.56 per month
	Silver £13.00 per month		Silver £26.00 per month
	Gold £20.00 per month		Gold £40.00 per month
	Platinum £27.50 per month		Platinum £55.00 per month
	Diamond £36.00 per month		Diamond £72.00 per month

12. Please confirm your Care4 life insurance premium:

Please also deduct the appropriate amount from my pay in respect of my Care4 policy as follows (tick one box only):

	Personal cover Covers policyholder only		Couple cover Covers policyholder and partner
	£2.70 per month		£4.68 per month

Total premium to be deducted from my salary £ **per month**

13. Please confirm your details:

Title | Surname | Forename(s)

Address

Town | County

Postcode | Date of birth

Signature

I hereby authorise the deduction from my salary/wages of the amount indicated (or such future amounts as may be required to secure the benefits of the selected policies) each month. Please remit same to BHSF on my behalf at the agreed intervals until further notice from me. This cancels any previous BHSF deductions authorised by me.

Signature | Date